



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
MISSOURI EYE EXAMINATION FORM FOR SCHOOL

IDENTIFYING INFORMATION		PATIENT/PROVIDER IDENTIFIER	
STUDENT NAME		PROVIDER LAST NAME (First Four Digits)	
DATE OF BIRTH OF STUDENT		SSN (Last four digits of student)	
PARENT / GUARDIAN NAME			
CASE HISTORY			
DATE OF EXAM			
OCULAR HISTORY:	Normal <input type="checkbox"/> or Positive for:		
MEDICAL HISTORY:	Normal <input type="checkbox"/> or Positive for:		
DRUG ALLERGIES:	NKDA <input type="checkbox"/> or Allergic to:		
FAMILY OCULAR and MEDICAL HISTORY:		<input type="checkbox"/> Amblyopia <input type="checkbox"/> Strabismus <input type="checkbox"/> Glaucoma <input type="checkbox"/> Diabetes	
		Other:	
OTHER PERTINENT INFORMATION			
EXAM			
	NORMAL	ABNORMAL	Not Able to Assess
AMBLYOPIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STRABISMUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTERNAL EYE HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXTERNAL EYE HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VISUAL ACUITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BINOCULAR VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OD	OS	
Distance Unaided Acuity (20 ft)	20 /	20 /	
Distance Best Corrected Acuity (20 ft)	20 /	20 /	
Near Unaided Acuity (14 in)	20 / (eq)	20 / (eq)	
Near Best Corrected Acuity (14 in)	20 / (eq)	20 / (eq)	
REFRACTION			
OD			
OS			
DIAGNOSIS			
<input type="checkbox"/> Normal <input type="checkbox"/> Myopia <input type="checkbox"/> Hyperopia <input type="checkbox"/> Astigmatism <input type="checkbox"/> Strabismus <input type="checkbox"/> Amblyopia			
OTHER:			
TREATMENT RECOMMENDATIONS			
1	Glasses Prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No		
2			
3			
Spectacles to be worn for:			
<input type="checkbox"/> Constant Wear <input type="checkbox"/> Distance Vision Only <input type="checkbox"/> Near Vision Only <input type="checkbox"/> May be removed for recess/PE			
PAYER			
<input type="checkbox"/> Insurance <input type="checkbox"/> MO HealthNet <input type="checkbox"/> Complimentary <input type="checkbox"/> Other form of payment			TOTAL COST:
EXAMINER NAME		<input type="checkbox"/> OD <input type="checkbox"/> MD/DO	DATE